Splendora Independent School District

23419 FM 2090, Splendora, Texas 77372
281-689-3128 • Fax 281-689-7509

PARENT/GUARDIAN: **RETURN FORM TO SCHOOL NURSE**

Parent/Guardian Name:_____

Student Name:_____

Campus Name:_____Student Grade:_____

Physician's Diet Modifications

Please complete this page for DISABILITIES/IMPAIRMENTS REQUIRING PHYSICIAN'S DIET MODIFICATION. The U.S. Department of Agriculture School Meals Program requires that all questions be answered in order for dietary substitutions and/or modifications to be made.

PHYSICIAN'S STATEMENT

I_____, Physician's Name (please PRINT)

Physician for _____Child's Name (please PRINT)

declare the herein mentioned child to possess the following severe/life-threatening food allergies and/or special dietary needs related to a disability.

Disability/Impairment requiring meal modification:_____

If food allergy, is it LIFE-THREATENING? _____yes _____no

Reason for diet restriction:_____

_____

_____

Foods to Omit:_____

_____

Foods to Substitute:_____

_____

Physician Signature: _____ Date:_____

Physician Name:_____

Physician Address:_____

Physician Phone Number:_____